Washington State Department of Social & Health Services

MAA Medical Assistance Administration

DIVISION OF MEDICAL MANAGEMENT
PRIOR AUTHORIZATION UNIT
SYNAGIS COORDINATION
1-800-848-2842

FAX this request to: (360) 725-2122

REQUEST FOR SYNAGIS

(Not Managed Care/Healthy Options)
Please include a cover sheet with this request

Please note that this medication must be pre-authorized before it can be administered to a client who is over one year of age. See WAC 388-530-1200 and WAC 388-530-1250

CHILD'S NAME LAST	FIRST	PIC NUMBER

DATE OF BIRTH	BIRTH WEIGHT	GESTATIONAL AGE
	Grams	Weeks

CLINICAL STATUS AT TIME OF REQUEST FOR SYNAGIS	CURRENT WEIGHT
	Kg Lbs/oz

	Yes	No
Diagnosis of BPD? (for BPD diagnosis, must meet criteria 1, 2 and either 3 or 4)	☐	☐
1. Persistent abnormal respiratory signs during first week of life.	☐	☐
2. Abnormal chest x-ray consistent with BPD	☐	☐
3. Supplemental 0^2 at 28 days of life	☐	☐
4. Supplemental 0^2 at 36 weeks gestational age* *A baby born at 26 weeks gestation would be 10 weeks of age when it reaches 36 weeks gestation	☐	☐
5. Chronic lung disease (non-BPD) If yes, specify	☐	☐
Congenital Heart Disease If yes, specify defect	☐	☐
Use of cardiac medications If yes, specify	☐	☐
Cyanotic	☐	☐
Failure to thrive If yes, describe severity and duration	☐	☐

CURRENT DAILY PULMONARY MEDICATIONS

☐ None ☐ Albuterol (and similar) ☐ Oxygen ☐ Steroids ☐ Intal ☐ Other

If not on meds currently:

Did the infant ever receive pulmonary medications? Yes ☐ No ☐

If yes, date of last daily use of pulmonary medications:

Pulmonary medications or treatments used in the past and dates used:

x	MEDICATION	DATES USED	x	MEDICATION	DATES USED
	Albuterol (and similar)			Intal	
	Oxygen			Other	
	Steroids				

Neonatal History	Yes	No
Intraventricular hemorrhage	☐	☐
Mechanical ventilation	☐	☐
Bacteremia	☐	☐
Necrotizing enterocolitis	☐	☐
Severe Neurological Impairment	☐	☐
If yes, diagnosis:		
Other severe systemic disease	☐	☐
If yes, specify:		

Socioeconomic Factors	Yes	No
More than one sibling under 5 years of age in household	☐	☐
Maternal smoking in same household	☐	☐
Maternal drug/substance abuse	☐	☐
Out-of-home (foster care) placement	☐	☐
Infant day care placement	☐	☐
Of Native American ethnicity	☐	☐
Severe social disarray (such as homeless parents, illicit drug use, etc.)	☐	☐
Other (specify)		

Has the infant already had one or more doses of Synagis this season? ☐ Yes ☐ No

DOSAGE	DATE DOSE GIVEN	WHERE DOSES GIVEN
1st dose		
2nd dose		
3rd dose		
4th dose		

Were any of the above doses approved and/or paid by another insurer? ☐ Yes ☐ No

If yes, please list:

IMPORTANT - If a pharmacy is providing billing for the Synagis, MAA must be informed prior to the authorization being completed.

	Yes	No
Pharmacy billing for Synagis using NDC	☐	☐
If yes, please provide billing pharmacy's NABP _____		
Physician office billing for Synagis using procedure code	☐	☐

If you have additional commentary/justification regarding this request, please include on the cover sheet.

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CLIENT'S AGE ON DECEMBER 1	BABY ON MOTHER'S PIC	DOSE ☐ 50 ☐ 100 ☐ 150 ☐ 200 ☐ 250 ☐ 300
NABP NUMBER	OR PROC/REV CODE MMIS AUTH:	50MG / 100MG
APPROVE	COMMENTS	

DENY

☐ Does not meet AAP criteria ☐ Child over 2 years of age ☐ Deny and refer for asthma consult

MD SIGNATURE	DATE